



Review Of Community Services Board Mental Health Case Management Services for Adults

Prepared by:
Office of the Inspector General
For Mental Health, Mental Retardation
& Substance Abuse Services

James W. Stewart, III
Inspector General

Report: #128-06

Office of the Inspector General
Review of Mental Health Case Management Services for Adults

Table of Contents

Section	Page
I. Executive Summary	5
II Background of the Study	11
III. Brief Description of Current Service Delivery System	17
IV. Quality of Care Findings and Recommendations	19
V. Appendix	47
A. Quality Statements and Indicators	49
B. Number of Adults Receiving Mental Health Case Management	53
C. Model for Delivery of MH Case Management Services	55
D. Average Case Management Caseloads Reported by CSBs	57
E. Case Manager Education/Licensure	59
F. Salaries for CSB Mental Health Case Managers	61
G. Survey Questionnaires and Checklists	62

(Actual documents are available with the website
version of this report found at www.oig.virginia.gov)

Section I

Office of the Inspector General Review of Mental Health Case Management Services for Adults

Executive Summary

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted a review of the statewide system of community services board (CSB) mental health case management services for adults during March 2006. This service was selected for review because it is considered an essential service for persons with serious mental illness and the provision of this service is mandated in the VA Code §37.2-500. Approximately 24,000 individuals were receiving mental health case management at the time of this review.

To assure that the review focused on current issues, the OIG invited the contribution of ideas from a wide range of stakeholders including consumers, advocacy groups, community and facility providers and the staff of the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS). The basis for the review was six Quality Statements for Case Management Services that were developed by the OIG (Attachment A). The review included a survey of all 40 CSBs and visits by OIG inspectors to 100% of the CSBs. During the site visits, interviews were conducted with 654 service users, 310 case managers, 83 division directors and case management supervisors, and 18 physicians. Over 400 service recipient case records were reviewed.

Quality of Care Findings and Recommendations

A. Consumer-Centered Services

The hallmark indicator of quality in case management services is the degree to which these services are designed, selected, and directed by the consumer.

Quality of Care Finding A.1: Case management service users and case managers agree that consumers have a significant role in developing their own service plans, however, case management records fail to reflect this.

Quality of Care Recommendation A.1: It is recommended that DMHMRSAS with the involvement of DMAS, CSBs and consumers, develop a model case management service planning system and format that is person-centered, reflects the principles of recovery, and meets all regulatory requirements.

Quality of Care Finding A.2: Case management service recipients have limited opportunity to exercise choice in the selection of case managers.

Quality of Care Recommendation A.2: It is recommended that CSBs review case management service delivery methods and procedures to identify ways in which consumers can exercise greater choice as recipients of this service.

B. Coordination of Services

A primary role of the case manager is to work with the consumer to be sure that his or her support needs are met in a coordinated, efficient, effective manner, making maximum use of available clinical and support services, and advocating for provision of needed services.

Quality of Care Finding B.1: Persons who receive adult case management services confirm that they receive the full range of case management services and that they consider each service to be important to them.

No recommendation

Quality of Care Finding B.2: OIG inspectors found little evidence that case managers routinely evaluate the effectiveness of the services received by the consumer as a part of the individual service plan.

Quality of Care Recommendation B.2: It is recommended that CSB case managers regularly assess the quality or effectiveness of services provided to consumers as a part of the individual service plan and the impact of these services on the consumer's quality of life.

Quality of Care Finding B.3: Consumers report that they are able to reach their case managers when needed during regular business hours but are not able to gain access to their case managers after hours and on weekends when they must deal with on duty staff in the emergency services program.

Quality of Care Recommendation B.3: It is recommended that CSBs investigate the use of systems by which consumers can reach their own case managers in times of crisis so that they might speak to someone they know and trust rather than routinely having to deal solely with the emergency services system after regular business hours.

Quality of Care Finding B.4: Consumers of mental health case management services face severe shortages of core services needed for successful recovery in the community – affordable housing, reliable transportation, support to get jobs, peer support providers, timely access to psychiatrists, and affordable medications. Case managers cannot link and coordinate services that are not available.

Quality of Life Recommendation B.4.a: In order to make available a more complete array of community services, it is recommended that DMHMRSAS and DMAS work cooperatively to seek avenues to steadily increase the capacity of the community services system to provide non-emergency support and clinical services.

Quality of Life Recommendation B.4.b: It is recommended that DMAS investigate the cost and feasibility of covering dental services for Medicaid recipients.

Quality of Life Finding B.5: Consumers of mental health case management services report that their rights and privacy are protected by the CSB.

No recommendation

C. Services Guided by the Recovery Model

By wide agreement of consumers, researchers, professionals, and state and national government leaders, the principles of the recovery model should be the basis for design and provision of mental health services. The principles of the recovery model are embodied in the Vision Statement of the DMHMRSAS.

Quality of Care Finding C.1: Case manager interviews and case management records do not reflect familiarity with or adoption of the recovery model.

Quality of Care Recommendation C.1: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop a model training curriculum for mental health case managers and that this program be made available to all CSBs.

Quality of Care Recommendation A.1 is also in support of this finding.

Quality of Care Finding C.2: Consumers express very high satisfaction with their case managers.

No recommendation

Quality of Care Finding C.3: Few CSBs have mission/value statements that closely parallel the concepts found in the vision, mission, values statements of DMHMRSAS.

Quality of Care Recommendation C.3: It is recommended that each CSB review its mission statement and value statements and make any changes needed to assure consistency with the system wide vision statement adopted recently by DMHMRSAS. Once this is done, each CSB should take the necessary steps to assure that the actions of staff at all levels and the culture of the program reflect the organizational mission and value statements.

Quality of Care Finding C.4: CSB case management programs do not make extensive use of trained peer support providers (“recovery coaches”) to augment and supplement services.

Quality of Care Recommendation C.4: It is recommended that DMHMRSAS and CSBs research “recovery coach” models for involving peer support staff in case

management and develop training programs to assist consumers in becoming qualified to provide this service. It is further recommended that CSBs offer peer support providers to complement and augment traditional case management services.

Quality of Care Finding C.5: Neither consumers nor case managers and supervisors expressed strong dissatisfaction or disapproval of the name case management. When informed that some consumers object to the term, most were open to considering alternative names for this service.

No recommendation

D. Consumer/Case Manager Connection

A strong, clinically sound interpersonal connection that fosters trust, cooperation and support is essential for effective case management services.

Quality of Care Finding D.1: Both service recipients and case managers report that they experience their relationship as a strong, positive connection.

No recommendation

Quality of Care Finding D.2: Consumers report that turnover of case managers is far too frequent to assure good continuity of care. Turnover of case managers varies significantly among CSBs.

No recommendation

E. Case Management Activity and Outreach

Case management is a vigorous, active service, with frequent face-to-face and collateral contacts provided at a level sufficient to assure positive outcomes, guided by consumer preferences.

Quality of Care Finding E.1: The frequency of face-to-face contact by CSB mental health case managers with consumers is significantly higher than the minimum requirements of Medicaid.

No Recommendation

Quality of Care Finding E.2: The location where case managers visit with consumers is split fairly evenly between home/community settings and office based settings.

Quality of Care Recommendation E.2: It is recommended that each CSB review current practice regarding the location where case managers visit with consumers to:

- Understand clearly what the current practice is.

- Identify barriers that may prevent visits in the location(s) preferred by consumers and most advantageous to the provision of effective services.

It is further recommended that each CSB:

- Assess whether or not current practice is consistent with consumer preference.
- Develop strategies for eliminating any identified barriers.
- Establish any guidance that may facilitate greater flexibility in where case management visits take place.

Quality of Care Finding E.3: Average caseload sizes for case management are higher than national standards and higher than case managers, supervisors, and consumers think is appropriate to ensure highest quality services.

Quality of Care Recommendation E.3.a: It is recommended that DMHMRSAS study the advisability of establishing a caseload standard for CSB case managers who work with individuals with serious mental illness and establish such a standard if it is determined advisable.

Quality of Care Recommendation E.3.b: It is recommended that DMHMRSAS seek additional resources to increase the number of CSB case managers who work with individuals with serious mental illness in order to lower the average caseload. If it is determined that a state standard for such caseloads is advisable, it is recommended that this standard serve as the guideline for determining how many additional case managers are needed.

Quality of Care Finding E.4: Case management service recipients have the same access to and receive the same level of case management service regardless of eligibility for Medicaid as a payment source. However, Medicaid recipients do have greater access to other services such as mental health support services, transportation, affordable medications and outpatient services.

Quality of Care recommendation B.4.a is also in support of this finding.

F. Case Manager Preparation and Support

Case managers must have sound clinical knowledge and the skills and training specific to the wide range of tasks a case manager must provide. Case management is an essential service and its providers must be supported and recognized as core mental health professionals.

Quality of Care Finding F.1: Case managers and supervisors have appropriate education levels for their positions.

No recommendations

Quality of Care Finding F.2: Case managers receive little training in topics specifically related to case management.

Quality of Care Recommendation F.2.a: It is recommended that DMHMRSAS and DMAS, with the involvement of CSBs, study the value of developing certification standards for case managers.

Quality of Care Recommendation F.2.b: It is recommended that CSBs consider the development of regional and/or statewide forums that will facilitate learning for case managers and enhancement of their professional role.

Quality of Care Recommendation C.1.a is also in support of this finding.

Quality of Care Finding F.3: Case managers, supervisors – even many consumers – are of the opinion that paperwork requirements interfere with service provision rather than support it.

Quality of Care Recommendation F.3: It is recommended that as DMHMRSAS and DMAS review and amend their respective regulations and inspection procedures that they seek ways to streamline and minimize data and record keeping requirements in an effort to allow case managers to maximize the amount of time they are available to consumers.

Quality of Care Finding F.4: Salaries for CSB case managers at some CSBs are very low. Low salaries are considered a major problem at some CSBs and contribute to high turnover and interference with the continuity of care.

Quality of Care Recommendation F.4: It is recommended that each CSB conduct a review to determine if current salary ranges for case managers are having any negative impact on continuity of care for consumers who receive case management services and develop strategies to address any problems that are identified.

Section II

Background of the Study

About the Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and providers as defined in VA Code § 37.2-403. This definition includes all providers licensed by DMHMRSAS including community services boards (CSB) and behavioral health authorities (BHA), private providers, and mental health treatment units in Department of Correction facilities. It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses and deficiencies and improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

Selection of Adult Mental Health Case Management for Review

Mental health case management services for adults was selected by the OIG for review for the following reasons:

- The provision of case management by Virginia's CSBs is mandated in the VA Code §37.2-500. It is one of only two mandated services for CSBs. The other mandated service is emergency services.
- Case management is required and defined by Virginia Mental Health, Mental Retardation and Substance Abuse Services State Board policy, performance contract, discharge planning protocols, and continuity of care policies.
- Although case management is considered an essential service for persons with serious mental illnesses and is provided widely across the nation in most communities, great variations in service models and types of case management are seen in professional literature and in practice. The types of case management in use in Virginia across the CSB system have never been documented.
- While CSBs are mandated to provide case management, who must receive case management is less clear. Screening and eligibility standards for case management may differ among the CSBs.
- There is a widespread impression that caseload sizes for CSB case managers are significantly larger than desirable for good services to consumers. Actual caseload sizes among CSBs are not known.
- Recovery, consumer empowerment and self-determination have been identified by DMHMRSAS as critical principles to guide the mental health service delivery

system. It is not known to what degree these values are reflected in the provision of case management services.

- Concern exists that there may be frequent turnover of case managers, which if true, would interfere with the establishment of effective working relationships between staff and consumers and decrease the effectiveness of case management services.
- Concern exists that the lack of adequate support services such as housing prevents case managers and consumers from developing individual plans of care that will adequately address the identified needs.
- Some in the consumer empowerment movement propose that consumers serve as case managers and express disapproval that the service is called “case management”. These consumers say, “We are not cases, and we don’t need to be managed.”
- Since 1991, the Department of Medical Assistance Services (DMAS) has provided a dedicated source of reimbursement for Targeted Case Management (TCM) for those who meet the eligibility requirements for Medicaid and for this service. CSBs report that a significant portion of adults with mental illness do not qualify for Medicaid. The degree to which those without Medicaid have access to case management services is unknown.

Design of the Review

The OIG began the study process by conducting an extensive literature search of indicators of quality in adult mental health case management services, as seen by persons who receive such services, program experts, academics, standard-setting organizations, family members and advocates. In addition, and in the fashion of previous OIG studies, input was sought on case management service quality indicators, concerns and issues from a wide variety of Virginia providers, stakeholders, and family members in both formal and informal settings.

A statewide conference on peer supports, hosted by DMHMRSAS in Charlottesville February 13-14, offered a unique opportunity for OIG staff to discuss case management issues with consumer activists, consumers-in-training to become peer supporters, experts from other states, and CSB staff. A telephone conference was hosted by the OIG on February 21 with participation by over 30 CSB representatives. A number of CSBs provided additional written commentary following the teleconference.

Input to the design of the review was received from DMHMRSAS leadership and central office staff (including the Office of Licensure and Office of Human Rights), DMHMRSAS facility directors, DMAS, and the Virginia Office on Protection and Advocacy (VOPA).

The OIG developed a set of six Mental Health Case Management Quality Statements from the research and input described above. (See Attachment A) These Quality Statements that are listed below include 31 separate indicators of quality.

1. Case management services are consumer-centered and consumer-driven.
2. Case management coordinates needed services in a comprehensive and efficient manner.
3. Case management services are guided by the recovery model and are a principle means for a consumer to plan and implement his/her own recovery.
4. Consumers and case managers share a constructive interpersonal helping connection that fosters trust, cooperation, and support for each consumer's recovery.
5. Case management is an active, positive service that reaches out to consumers and provides continuing, active supports.
6. Case managers are qualified, well prepared, and supported in their roles.

Development of survey instruments

OIG staff developed structured interview instruments that addressed each of the indicators in the quality statements, many from more than one point of view. Where possible, these interview instruments were based on questionnaires or other evaluation tools found in the professional and consumer literature or tools that had been used before in Virginia. Portions of the consumer survey were drawn from consumer-developed service evaluation measures, including the Recovery Oriented Survey Instrument (ROSI).

The instruments and the review process were field tested at the Goochland-Powhatan CSB on February 24. After administration of the instruments, suggestions for improvement were sought from consumers and case managers. A second field test on March 3, at the Crossroads CSB, repeated this process of instrument and review design refinement and also served as a training session for OIG staff.

All survey questionnaires and checklists can be found in Appendix G in the version of the report that is located on the OIG website (www.oig.virginia.gov).

Process of the review

In order to assure that this review would provide a comprehensive understanding of mental health case management services for adults in Virginia, the decision was made to conduct a complete inspection of 100% of the 40 CSB case management programs. A major factor in this decision was the lack of statewide information that was available about this important service.

This review included all CSB mental health case management services for adults except case management that is provided through Assertive Community Treatment Teams (PACT) or other multi-disciplinary teams in which all members of the team share case management responsibilities for all consumers served by the team. As a practical matter

and to focus on the essence of the case management service, the OIG excluded the PACT-type service models from the review.

All CSBs received a letter from the Inspector General dated February 14, 2006, announcing the review and inviting representatives to participate in the input sessions described earlier in this report. In this letter, each CSB was asked to submit a listing of the names of all case managers to the OIG. On February 27, an email was sent to the 40 CSBs requesting that they complete the Survey of Adult Mental Health Case Management Services and return it by March 12. This survey assessed numbers of consumers served, percentage of consumers with Medicaid, caseload size, full time equivalent case management staffing, along with other issues.

From March 6 to March 31, site visits were made by the OIG to all CSBs, with the exception of the two CSBs that had been visited as test sites. The majority of CSB inspections was conducted by a single inspector. Cathy Hill, John Pezzoli, Jim Stewart, and part-time consulting staff Jonathan Weiss and Ann White comprised the project team. John Pezzoli served as Project Manager for this review. Cathy Hill coordinated data entry and data analysis, working with Heather Glissman.

Each CSB received an email notification from the OIG five days in advance of the selected site visit date. This message: 1) announced the date of the inspection, 2) described the schedule for the day, 3) identified the names of eight case managers, selected at random by the OIG, who would be interviewed during the visit, 4) provided guidance to the CSB on selection of records for review, and 5) provided guidance for selection of eight to ten consumers who would be interviewed by OIG staff. All visits were completed in a single day, except for the Fairfax-Falls Church CSB, which received a two-day visit.

Site visits began with interviews of the case management unit supervisor and the division director who oversee case management services. Case records were then reviewed. The OIG inspector selected eight records from a batch of ten records that had been gathered by the CSB in advance using criteria provided by the OIG. Selected records were to include a 50:50 ratio of Medicaid and non-Medicaid consumers and were to include records of those case managers who would be interviewed.

Separate group interview sessions were then held with consumers and case managers, usually around eight persons per group. In the group interviews, OIG staff explained the pencil and paper survey forms and then supervised the completion of the forms by those in each group. After the anonymous questionnaires were completed and collected, the OIG staff led separate group discussions regarding case management related issues with both case managers and consumers.

In order to significantly increase the number of consumers who would be interviewed, the OIG employed CSB consumers at 39 of the 40 CSBs to interview an additional six to ten consumers at each CSB. The CSBs were invited to recommend consumer interviewers who had previously received some sort of training such as WRAP, CELT or VHS. The

OIG inspector trained the selected consumer to conduct interviews using the same interview format and form. The consumer interviewer was responsible for selecting the group of consumers to be interviewed. All completed forms were to be mailed to the OIG within two weeks of the CSB inspection.

CSBs were asked to make medical directors or psychiatrists available for brief interviews scheduled at the convenience of the physician, in person or by telephone. Given the tight schedules of the physicians, it was not always possible to interview a physician.

The following summarizes the scope of the statewide review of mental health case management services:

- 40 CSBs completed the Survey of Adult Mental Health Case Management Services.
- 654 mental health case management service users were interviewed including:
 - 319 individuals interviewed by OIG staff during the site visits.
 - 335 individuals interviewed by 37 peer interviewers who were employed by the OIG.
 - This is 2.73% of the 23,948 persons receiving case management at the time of the study.
- 310 case managers were interviewed.
 - This is 36.7 percent of the total number of case managers employed by CSBs (people, not FTE's) at the time of the review. Case managers who serve on PACT teams or other multi-disciplinary teams were excluded from this project.
- 403 service recipient case records were reviewed.
- 83 division directors and case management supervisors were interviewed.
- 18 doctors were interviewed.

Section III

Brief Description of Service Delivery System

Number of Individuals Receiving Case Management

The OIG surveyed all 40 CSBs to collect information about the total number of persons receiving CSB mental health case management services throughout Virginia.

- CSBs reported serving 37,392 persons with serious mental illness.
- Of this number, 23,948, or 64 percent were receiving adult mental health case management services.
- The percentage of persons with serious mental illness receiving case management services at the 40 CSBs ranged from a low of 22 percent to a high of 100 percent.
- Fifty-two percent of those receiving case management services had Medicaid; 48 percent did not.
- The percentage of persons receiving case management with Medicaid ranged from a low of nine percent to a high of 95 percent

Attachment B provides information about the total number of persons receiving CSB mental health case management by individual CSB.

Models for Delivering Case Management Services

Through surveys and interviews with service directors and case management supervisors, the OIG obtained information about the structures and protocols used by CSBs to deliver mental health case management services to adults.

- CSBs deliver the majority of case management services through teams that are structured in one of two ways. These two structures include 1) Dedicated Case Management Teams in which case management is the sole or primary service provided by the staff and 2) Multifunctional Teams in which staff performs not only case management duties, but also a second service, most often outpatient therapy or mental health support services.
 - Thirty-six of the 40 CSBs (90%) operate one or more Dedicated Case Management Teams. This is the predominant structure for delivering case management services.
 - Five of these 36 CSBs that operate Dedicated Case Management Teams also operate one or more Multifunctional Teams. These five CSBs include: Alexandria, Central Virginia, Fairfax-Falls Church, Mr. Rogers and Prince William.

- Four of the 40 CSBs (10%) do not operate Dedicated Case Management Teams and provide all case management through Multifunctional Teams. These four CSBs include: Arlington, Dickenson, Hanover, and Loudoun.
- Fifteen CSBs have organized case management into tiers of service based on severity of need or level of functioning, with reduced staff-to-consumer ratios for consumers with greater severity of need.
- Twenty-three CSBs feature heterogeneous caseloads, mixing consumers with different levels of needs, without tiered or stratified service ratios.
- Thirteen CSBs have established caseload limits or caps for their case managers.
- Eight CSBs have developed waiting list protocols that restrict access to case management services when prescribed staff-to-consumer ratios are reached. In most cases this is done to prevent dilution of the service. Often, those who must wait for assignment to a case manager receive other services such as medication management during the waiting period.

Attachment C provides information about structures and protocols by individual CSB.

Additional descriptive information about case management services can be found in Section IV of the report where findings and recommendations are described.

Section IV

Quality of Care Findings and Recommendations

The findings and recommendations that follow have been grouped according to the six Quality Statements for adult mental health case management services.

A. Consumer-Centered Services

The hallmark indicator of quality in case management services is the degree to which these services are designed, selected, and directed by the consumer.

Quality of Care Finding A.1: Case management service users and case managers agree that consumers have a significant role in developing their own service plans, however, case management records fail to reflect this.

- The OIG asked consumers and case managers the following questions to gain an understanding of the consumer's role in developing the individual service plan. The same questions were used as a method for rating the degree of consumer involvement in the development of service plans as reflected in the individual case record.

Which of these statements best describe how consumers' plans and goals are developed?	Consumer Responses	Case Manager Responses	OIG Findings from CM Records
Case manager develops individual services plan (ISP) for the consumer, explains it, and asks consumer to sign it.	32%	14 %	63%
Case manager involves consumers in developing their ISP, inviting the consumer to help create goals.	50%	75%	34%
Consumers substantially lead the development of their own need assessment and ISP, in their own words, with case manager supports.	19%	11%	3%

- The majority of consumers (69%) report that they play a significant role in the development of their own service plan either by participating with the case manager or taking the lead.
- A somewhat larger percentage of case managers (86%) report that the consumers are significantly involved in developing the plans.

- OIG review of records did not reveal significant evidence of consumer involvement in the development of their own individual service plans. Only 37% of the records reviewed had sufficient evidence of real consumer involvement in development of their plan. Based on the very positive answers provided by both consumers and case managers, these results suggest that the case records do not accurately represent the degree of consumer involvement in the development of individual service plans. Triggers for OIG staff to judge records as having consumer involvement included explicit reference to consumer involvement in the process, use of quotes or references to state consumers' preferences or input in their own language, avoidance of prescriptive language such as "client will remain medication compliant," dedicated sections or pages that allowed or required consumer input, presence of WRAP plans, presence of crisis plans.
- In reviewing the case records, the OIG staff did note that the consumer-provider relationship described in progress notes often seemed to characterize a consumer-led, shared decision-making process that supports the values that case managers espoused in their interviews.
- Many CSB case management supervisors stated that assuring documentation in the record that conveys fulfillment of the Medicaid and DMHMRSAS requirements is not easily compatible with documenting the consumer's involvement in the planning process.
- DMAS mental health policy staff indicates that person-centered planning is very much consistent with Medicaid policies and values and that they support this approach.
- OIG staff did find that case management records at some CSBs reflect various degrees of person-centered planning.

Quality of Care Recommendation A.1: It is recommended that DMHMRSAS with the involvement of DMAS, CSBs and consumers, develop a model case management service planning system and format that is person-centered, reflects the principles of recovery, and meets all regulatory requirements.

DMHMRSAS Response: *DMHMRSAS will refer this recommendation to the System Operations Team, to identify and convene a Case Management Workgroup to (1) define a recovery-oriented, evidence-based case management service model, (2) make recommendations on case manager credentialing, (3) develop caseload standards, if advisable, (4) identify a training curriculum to support implementation of the case management model, and (5) identify resources, including DMHMRSAS staff, needed for sustaining and supporting the recommended model on an ongoing basis.*

The membership of the Case Management Workgroup will include at a minimum representatives from DMHMRSAS, CSBs, DMAS, consumers, and family members. The Workgroup will work in partnership with other groups including the Consumer Service Record Workgroup and the Recovery Education and Training Committee to build on and coordinate activities relative to case management.

Target date: Convene Workgroup by November 15, 2006. Preliminary recommendations regarding model, credentialing, caseload standards, curriculum and necessary resources by August 1, 2007

Quality of Care Finding A.2: Case management service recipients have limited opportunity to exercise choice in the selection of case managers.

- Consumers were asked to rate three indicators that would provide some understanding of the degree to which they have a choice of case manager and an opportunity to evaluate the services received or the case manager.

Consumers' Valuation of Choice of Case Management	Rated Important	Received	Percentage Difference
When I first entered case management, I was able to interview and select my own case manager	74%	29%	45%
I am able to change to a different case manager if I wish.	80%	56%	24%
I have opportunities to evaluate the quality of the case management services I receive.	92%	70%	22%

- As can be seen in the above chart, it is very important to consumers to be able to select and change case managers as they feel needed, however, they report that this opportunity for choice is not made available by CSBs to the extent that it is desired and felt to be important. This chart also shows that 70% of consumers report that they have the opportunity to evaluate their case management services.
- Case managers and supervisors noted that provision of choice of case managers at service entry is hampered by high caseloads and limited case management staffing. Some indicated that they do ask whether the consumer might prefer a male or female case manager and other choice elements when possible. All CSBs reported that consumers could change case managers if they so request. Some of the boards reported that they have an established process that requires the consumer to have an interview to explain his or her reasons for wanting a change.

Quality of Care Recommendation A.2: It is recommended that CSBs review case management service delivery methods and procedures to identify ways in which consumers can exercise greater choice as recipients of this service.

DMHMRSAS Response: *DMHMRSAS strongly supports this finding and will continue to encourage and support CSBs to integrate consumer direction and choice into case management services.*

B. Coordination of Services

A primary role of the case manager is to work with the consumer to be sure that his or her support needs are met in a coordinated, efficient, effective manner, making maximum use of available clinical and support services, and advocating for provision of needed services.

Quality of Care Finding B.1: Persons who receive adult case management services confirm that they receive the full range of case management services and that they consider each service to be important to them.

- Consumers were asked to respond to the following list of nine typical case management activities or services by indicating first, whether they receive that service or activity from their case manager and, second, how important it is to them. Case managers were asked to indicate whether or not each service is provided and to rate the importance of each service. The list of services and activities was drawn from DMAS and DMHMRSAS requirements, professional and consumer literature about case management, and CSB and consumer input to the OIG.

Case Management Service	Consumers Responses			Case Managers Responses		
	% Who Rated Service Received	% Who Rated Service Important	% Difference	% Who Rated Service Received	% Who Rated Service Important	% Difference
My case manager makes sure all my services work together to give me the most help.	92%	99%	7%	94%	99%	5%
My case manager works with my family – if I want him or her to.	62%	75%	13%	99%	99%	0%
My case manager provides supportive counseling to me.	89%	96%	7%	95%	100%	5%
My case manager provides crisis support service when I need it.	83%	95%	12%	98%	100%	2%
My case manager makes arrangements and makes sure that I receive medical services.	80%	91%	11%	96%	100%	4%
My case manager makes sure that I have transportation to appointments, etc.	71%	87%	16%	94%	99%	5%
My case manager makes sure that I receive educational services about mental illness, medications, coping skills, etc	78%	94%	16%	91%	99%	8%
My case manager helps me manage my money, or finds someone who can help me, if I need it.	50%	66%	16%	92%	98%	6%
If I am hospitalized, my case manager continues to work with me and helps plan my discharge, return to the community, and follow up care.	66%	90%	24%	79%	95%	16%

- The services that are received by the largest percentage of consumers are:
 - Coordination of services (92%)
 - Supportive counseling (89%)
 - Crisis support (83%)
 - Arranging for medical services (80%)
 - Education about mental illness and mediation (78%)
- A majority of consumers reported receiving all of the services except one - help in managing money (50 %). Many persons who answered that they do not receive help managing their money reported that they did not need such help – so reporting that they do not receive it is consistent with their wishes.
- Consumers rated nearly every service or activity as “very important” or “important.” Case managers’ help in coordinating services, providing supportive counseling, and providing crisis assistance were the highest ranked, with each over 95 percent.

- Record reviews by OIG inspectors confirmed case manager and consumer comments regarding services received. OIG staff counted various types of case management activities that had been documented in the record during the preceding 90 days. This chart summarizes the findings:

Case Management Service	Percent Provided in Quarter Reviewed
Linkage and Coordination of Services	93%
Supportive Counseling	85%
Arrangement of Medical Services	68%
Education/Supports on Psychiatric Meds	54%
Contact with Family or Natural Supports	26%
Crisis Support Services	11%

No recommendation

Quality of Care Finding B.2: OIG inspectors found little evidence that case managers routinely evaluate the quality or effectiveness of the services received by the consumer as a part of the individual service plan.

- In the record review portion of the inspections, OIG staff counted various types of activities performed by the case managers that had been documented in the record during the preceding 90 days. Of 403 records that were reviewed, only 89 (22%) indicated that the case manager had evaluated either the quality or effectiveness of other services received by the consumer.

Quality of Care Recommendation B.2: It is recommended that CSB case managers regularly assess the effectiveness of services provided to consumers as a part of the individual service plan and the impact of these services on the consumer's quality of life.

***DMHMRSAS Comment:** DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation.*

Quality of Care Finding B.3: Consumers report that they are able to reach their case managers when needed during regular business hours but are not able to gain access to their case managers after hours and on weekends when they must deal with on duty staff in the emergency services program.

- Consumers and case managers were asked to rate the following two statements regarding consumer accessibility to case managers.

Case Manager Accessibility	Consumers Responses			Case Managers Responses		
	% Who Rated Service Received	% Who Rated Service Important	% Difference	% Who Rated Service Received	% Who Rated Service Important	% Difference
My case manager (not Emergency Services) is available for contact in the evenings or weekends if needed.	37%	80%	43%	24%	57%	33%
My case manager is easy to reach by phone.	84%	95%	11%	98%	100%	2%

- Literature on consumer preferences for services stresses the desirability of having a case manager who is easy to reach and returns calls promptly. Eighty-four percent of Virginia CSB consumers reported that their case manager meet this standard during regular business hours. Consumers and case managers agreed that this is important.
- Only 37 percent of consumers indicated that they could contact their case manager outside of normal office hours. While 24 percent of case managers reported that their consumers are able to reach them after hours, none of the CSB service directors reported that case managers are required to make themselves available after hours. The standard practice is for CSB emergency services programs to respond to consumers after hours. Some CSB emergency services programs have a protocol to contact the case manager under certain circumstances. Many case managers told the OIG inspectors that they do allow some contact by consumers after hours.

Quality of Care Recommendation B.3: It is recommended that CSBs investigate the use of systems by which consumers can reach their own case managers in times of crisis so that they might speak to someone they know and trust rather than routinely having to deal solely with the emergency services system after regular business hours.

DMHMRSAS Comment: DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation.

Quality of Care Finding B.4: Consumers of mental health case management services face severe shortages of core services needed for successful recovery in the community – affordable housing, reliable transportation, support to get jobs, peer support providers, timely access to psychiatrists, and affordable medications. Case managers cannot link and coordinate services that are not available.

- Consumers and case managers were asked to respond to the following questions regarding availability of core services:

Core Service Availability	Consumers Responses			Case Managers Responses		
	% Agree	% Disagree	Difference	% Agree	% Disagree	Difference
I see a psychiatrist when I want or need to, without undue waiting.	73%	27%	46%	37%	63%	26%
I see a therapist if I want and need to.	79%	21%	58%	70%	30%	40%
I have safe, affordable housing of my choice.	77%	23%	54%	21%	79%	58%
I have access to job training, job support, or jobs.	71%	29%	42%	60%	40%	20%
I have choice and self-determination in my treatment at my CSB.	88%	12%	76%	88%	12%	76%
I have access to affordable or free medications as prescribed.	86%	14%	72%	57%	43%	14%
I can access help when I have a crisis in my home or own community – not just hospitals	86%	14%	72%	82%	18%	64%
I have social opportunities, friendships, and relationships.	87%	13%	74%	82%	18%	64%
I have a chance to work with other persons who have experienced mental illness (other consumers), not paid staff, if I wish.	79%	21%	58%	29%	71%	42%

- Case managers have strong opinions about the lack of needed services in the community for the persons they serve. Following are the services they reported are least available and the percentage of case managers who expressed the concern:
 - Safe, affordable housing of consumer's choice – 79%
 - Chance to work with others who have experienced mental illness – 79%
 - Access to psychiatrist without delay – 63%
 - Access to affordable or free medications as prescribed – 43%

- Access to job training, job support or jobs – 40%
 - Access to reliable transportation for transport to/from services and for community integration activities was also mentioned.
- Consumers expressed the opinion that core services were generally more available than the case managers indicated.
- The severe lack of community mental health services has been documented by CSBs and the DMHMRSAS through the State Comprehensive Plan for years. The recent OIG Review of the Virginia Community Services Board Emergency Services Programs (Report #123-05) included Access Finding 4 that stated, “Non-emergency support and clinical services provided in the community do not have adequate capacity. As a result, Emergency Services Programs (ESPs) deal with crisis situations that could have been prevented if the consumer had received more intensive and or a different array of services.”
- Case managers consistently mentioned lack of access to dental services as a major services gap. The lack of dental services applies equally to consumers with and without Medicaid, as Medicaid does not cover dental services. The few charitable sources of free or low cost dentistry are overwhelmed; consumers commonly face 18-month waits for services. Case managers and CSB doctors reported chronic dental pain as an immeasurable, but very likely strong contributor to stress for consumers. They indicated that this increases the chances of psychiatric emergencies and hospitalization. Unlike the findings of the recent OIG Review of Community Residential Services for Adults with Mental Retardation (OIG Report #126-05), in which it was found that group homes and sponsored placements somehow arrange access to dental care for residents, mental health case management consumers are not able to access dental services as needed.
- Advocates of mental health services for persons who are deaf note that service gaps exist for this population in all areas of Virginia. (DMHMRSAS Advisory Council, Persons who are Deaf, Hard of Hearing, Deaf Blind, and Late Deafened)

Quality of Life Recommendation B.4.a: In order to make available a more complete array of community services, it is recommended that DMHMRSAS and DMAS work cooperatively to seek avenues to steadily increase the capacity of the community services system to provide non-emergency support and clinical services.

DMHMRSAS Response: *DMHMRSAS recognizes that a more complete array of services, such as affordable housing, reliable transportation, employment supports, peer support providers, timely access to psychiatrists, and affordable medications, is needed in order for consumers to work towards successful recovery in the community.*

Revamping and expanding Medicaid covered services that are aligned with recovery practices is envisioned in the Integrated Strategic Plan. DMHMRSAS meets regularly with DMAS to discuss and resolve issues of policy and services. Through the CMS Mental Health System Transformation Grant, DMHMRSAS, DMAS, DRS, CSB providers, and consumers are exploring other potential avenues for the enhancement of Medicaid reimbursement for peer specialists and the evidence-based practices of supported employment, PACT, and Illness Management and Recovery.

In addition, agencies under the Secretary of Health and Human Resources and the Secretary of Transportation have formed the Interagency Transportation Council for the purpose of improving the accessibility and coordination of transportation services for the elderly, persons with low income, and persons with disabilities. DMHMRSAS participates on this taskforce and will continue to do so.

DMHMRSAS is fully committed to expanding non-emergency support and clinical services.

Collaboration with DMAS is essential to expanding these services, but DMHMRSAS is committed as well to seeking state and federal funding that can support non-emergency support and clinical services. DMHMRSAS recognizes that safe and affordable housing of the consumer's choosing is a priority by case managers in this study. This is not an issue that will be resolved through Medicaid. However, DMHMRSAS currently collects, reviews and disseminates strategies employed by other States that have achieved successful expansion of affordable housing options and will continue to advocate for additional housing resources through Virginia's Olmstead Implementation planning process. The Department collaborated with Virginia Housing Development Authority in arranging a "Housing Seminar" on July 18.

Target date: Ongoing

Quality of Life Recommendation B.4.b: It is recommended that DMAS investigate the cost and feasibility of covering dental services for Medicaid recipients.

DMAS Response: DMAS will include this recommendation in its upcoming study/review of the MR Waiver to begin in the summer of 2006.

Quality of Life Finding B.5: Consumers of mental health case management services report that their rights and privacy are protected by the CSB.

- Ninety-one percent of the consumers who were interviewed reported that their rights and privacy are protected by the agency. Case managers agreed.

No recommendation

C. Services Guided by the Recovery Model

By wide agreement of consumers, researchers, professionals, and state and national government leaders, the principles of the recovery model should be the basis for design and provision of mental health services. The principles of the recovery model are embodied in the Vision Statement of the DMHMRSAS.

Quality of Care Finding C.1: Case manager interviews and case management records do not reflect familiarity with or adoption of the recovery model.

- Of the records reviewed, only 46 (11%) were judged to reflect a recovery orientation; 89 percent did not. OIG inspectors reviewed needs assessments, individual service plans, goals, quarterly reviews, and progress notes for the language and spirit of the recovery model. Hope, vision of progress and recovery, consumer self-determination and choice, consumer-directed plans and services were among the triggers for a summary judgment of general compliance with recovery principles.
- Sixty-three percent of case managers said they have received training in the recovery model in the past two years, however, only 4 CSBs reported having provided recovery model training for case managers.

Quality of Care Recommendation C.1: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop a model training curriculum for mental health case managers and that this program be made available to all CSBs.

DMHMRSAS Response: As referenced in the response to Recommendation A.1, the Case Management Workgroup will identify a recovery-oriented case management curriculum in collaboration with other related workgroups. Resources needed to implement such training on an ongoing basis will need to be identified.

Target date: As described above, convene Workgroup by November 15, 2006. Preliminary recommendations regarding model, credentialing, caseload standards, curriculum and necessary resources by August 1, 2007

Quality of Care Recommendation A.1 is also in support of this finding.

Quality of Care Finding C.2: Consumers express very high satisfaction with their case managers.

- Thirteen questions asked users of case management services to evaluate various aspects of their interaction with their case managers. These items assess consumer satisfaction with the supports they receive from their case managers, especially with regard to their quest for recovery. These indicators, drawn from the ROSI Survey (Recovery Orientation Survey Instrument) were administered to

654 mental health case management service users – 319 interviewed by OIG inspectors and 335 interviewed by 37 consumer peers hired by the OIG.

Questions Regarding Case Manger	Responses of Consumers Interviewed By OIG		Responses of Consumers Interviewed by Peers		Combined Consumer Responses	
	% Agreed	% Disagreed	% Agreed	% Disagreed	% Agreed	% Disagreed
My case manager listens carefully to what I say.	95%	5%	93%	7%	94%	6%
My case manager sees me as an equal partner in my treatment program.	94%	6%	88%	12%	91%	9%
My case manager treats me as a whole person, not as a psychiatric label or “case.”	91%	9%	91%	9%	91%	9%
My case manager does not understand my experience as a person with mental health problems.	23%	77%	28%	72%	26%	74%
My case manager leads me to be more dependent, not more independent.	35%	65%	40%	60%	38%	63%
My case manager ignores my physical health.	17%	83%	24%	76%	20%	80%
My case manager sees me when I need to be seen.	91%	9%	87%	13%	89%	11%
My case manager supports my self-care and wellness.	94%	6%	92%	8%	93%	7%
My case manager stands up for me to get the resources and services I need.	92%	8%	90%	10%	91%	9%
My case manager helps me build on my strengths.	90%	10%	89%	11%	90%	10%
My case manager is at least one person who believes in me.	89%	11%	88%	12%	89%	11%
My case manager treats me with respect regarding my cultural background (race, language, etc.)	94%	6%	93%	7%	93%	7%
My case manager believes that I can grow, change, and recover	93%	7%	93%	7%	93%	7%

- All thirteen items received highly favorable ratings – all but three at 87 percent or better. The three items that received the lowest favorable ratings are constructed somewhat differently than the other ten statements – a favorable response requires a “disagree” answer, rather than an “agree” answer, like the other 10 items. Though interviewers attempted to alert respondents to this difference, it is possible that misunderstanding of these items explain the lower ratings of these items as compared to the pattern of the other responses.
- Discussion with OIG interviewers confirmed that all but a very few consumers are very happy with their case managers. Many touching and humorous stories of their closeness to their service providers were reported. Similar reports of affection and closeness for the persons they serve were widely noted among case managers.

No recommendation

Quality of Care Finding C.3: Few CSBs have mission/value statements that parallel the concepts found in the vision, mission, values statements of DMHMRSAS.

- All 40 CSBs shared their mission statements with the OIG. The OIG analyzed each of these statements against the key elements in the DMHMRSAS statements (consumer-focused, recovery, community participation, self determination, high quality services, and stewardship of resources).
- Only four (10%) of CSBs have mission and value statements that closely reflect the DMHMRSAS vision and value statements, including all the key references.
- Six other CSBs (15%) have mission and values statements that include at least four of the key references.

Quality of Care Recommendation C.3: It is recommended that each CSB review it’s mission statement and value statements and make any changes needed to assure consistency with the system wide vision statement adopted recently by DMHMRSAS. Once this is done, each CSB should take the necessary steps to assure that the actions of staff at all levels and the culture of the program reflect the organizational mission and value statements.

DMHMRSAS Comment: *DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation.*

Quality of Care Finding C.4: CSB case management programs do not make extensive use of trained peer support providers (“recovery coaches”) to augment and supplement services.

- OIG staff observed little use of peer providers in case management.

Quality of Care Recommendation C.4: It is recommended that DMHMRSAS and CSBs research “recovery coach” models for involving peer support staff in case management and develop training programs to assist consumers in becoming

qualified to provide this service. It is further recommended that CSBs offer peer support providers to complement and augment traditional case management services.

DMHMRSAS Response: *In addition to the OIG recommendation here, the Wellness and Recovery Management Workgroup of the CMS Real Choice Systems Change Grant has also recommended that: “The number and types of peer support services and peer support training programs should be expanded. Several peer-provider training programs should be designed to meet the paraprofessional provider qualifications found in the current Medicaid regulations in order to increase the number of reimbursable peer providers.”*

Through the Recovery Education and Training Workgroup and the Community Mental Health Block Grant, DMHMRSAS is initiating planning for peer support specialist training that would enable more consumers to function in a variety of roles, including case managers and recovery coaches, within the existing mental health system.

DMHMRSAS also funds consumer- operated services and programs through the CMHS Mental Health Block Grant that provide consumers with additional choices and resources for maximizing their recovery, empowerment and self-determination.

Target date: DMHMRSAS plans to issue a Request for Proposals for Peer Specialist Training by October 30, 2006.

Quality of Care Finding C.5: Neither consumers nor case managers and supervisors expressed strong dissatisfaction or disapproval of the name case management. When informed that some consumers object to the term, most were open to considering alternative names for this service.

- Consumers were asked if they were to name case management something else, what would it be? Most consumers did not respond to this question, but of those who did, the majority concluded that case management is an adequate name for the service and recommended no change.
- Half the case managers who answered this question said no change is needed. Eight percent said they do not like the name, but suggested no alternative.
- When OIG staff mentioned such names as support services coordinator or recovery coach, case managers often responded positively.
- More than a hundred alternative names were suggested, with none gathering more than a handful of votes. Those that were mentioned most often included care coordinator, service coordinator and recovery coach. Some names, while perhaps apt, were suggested in humor: jack-of-all-trades, s/he who does everything, chart monitor person (from case managers), and guardian angel (from a consumer).
- Although some discomfort with the name was mentioned by a number of supervisors interviewed, few offered suggestions for changes. Most did not feel it was an issue for the consumers, in general. Several persons interviewed reported that the name devalues not only the consumers but suggests that the services

- provided are “lesser than” other forms of intervention such as therapy, thus having a negative impact on case managers.
- In the discussion period after the questionnaire was administered, OIG interviewers mentioned that some consumer leaders have criticized the name case management, suggesting that “we are not cases and we don’t need to be managed.” Many then reacted favorably to other popular options such as “care coordinator” or “recovery coach,” but very few strong opinions were expressed.

No Recommendation

D. Consumer/Case Manager Connection

A strong, clinically sound interpersonal connection that fosters trust, cooperation and support is essential for effective case management services.

Quality of Care Finding D.1: Both service recipients and case managers report that they experience their relationship as a strong, positive connection.

- Consumers value the personal connection with their case managers. In response to a question asking what consumers most like about case management, they offered comments like “case management helps me,” “(it gives me) someone to talk to,” “(case managers are) caring and honest,” and “(I get) support and encouragement.”
- Case managers find meaning and satisfaction in helping the people they serve.
 - In response to a question asking what case managers most like about their jobs, nearly 80 percent said that they feel they are making a difference and that they enjoy helping people and seeing the persons they serve improve.
 - In another question, which asked case managers to say what they like least, the second-highest dislike was not being able to help people with all they need – a consumer-centered, rather than self-centered response.
- Consumers and case managers agree that the case management services provided are needed and valuable. Responses to questions asking consumers and case managers to assign value to typical case management services showed a very high degree of positive agreement. (Data reported in Quality of Care Finding B.1.)
- Ninety-six percent of case managers report that the persons they serve value what they do for them.
- CSB psychiatrists who were interviewed said that the case managers help them understand the needs of the consumers they serve. Most used a phrase like “they are my eyes and ears when the (consumer) is not here.” All consider case management an invaluable service.

No recommendation

Quality of Care Finding D.2: Consumers report that turnover of case managers is far too frequent to assure good continuity of care. Turnover of case managers varies significantly among CSBs.

- Consumers reported the following regarding continuity of care with case managers:
 - 48% less than one-year experience with the same case manager
 - 67 % less than two years experience with the same case manager
 - 41% three or more case managers in five years.
- Case managers, however, report lengthier continuity with consumers.
 - The average tenure with the same caseload for CSB case managers was 3.9 years. (March 2006)
 - Ninety-three percent of case managers say they are “able to continue my supportive relationship with the persons I serve for a period long enough to not cause disruption or strain to the consumers’ need for continuity.”
- Supervisors at the various CSBs have varying opinions regarding the extent to which staff turnover is a problem. Service directors and supervisors agreed at 16 CSBs that turnover is a problem for continuity of care. At 17 CSBs, the directors and supervisors concurred that turnover is not a problem. At six CSBs the directors and supervisors offered conflicting opinions on this issue.
- Case managers report the following dissatisfactions with their jobs:
 - Paperwork demands - 60%
 - Lack of needed services such as Medicaid, affordable housing options, dental care to meet consumer needs - 19%
 - Large caseload size - 12 %
 - Low salaries - 10 %
 - Lack of respect for the role of case manager – 4%
- Agency reorganizations and transfer of staff are as disruptive to continuity of care as turnover of case managers. Some supervisors recognized the unintended negative effects on continuity of care resulting from administrative decisions that may have been made by the agency.

No recommendation

E. Case Management Activity and Outreach

Case management is a vigorous, active service, with frequent face-to-face and collateral contacts provided at a level sufficient to assure positive outcomes, guided by consumer preferences.

Quality of Care Finding E.1: The frequency of face-to-face contact by CSB mental health case managers with consumers is significantly higher than the minimum requirements of Medicaid.

- The OIG reviewed 403 consumer records in order to document the number of face-to-face interviews by case managers with consumers during the previous 90

- days and to determine the location of these visits. OIG inspectors counted documented face-to-face contacts over the 90 days prior to the inspection date by reviewing individual progress notes and service coding in a sample of records (normally ten records per board, with minor exceptions).
- An average of five documented face-to-face contacts between case managers and the persons they served occurred in the 403 records during the quarter, greatly exceeding the Medicaid minimum requirement of one face-to-face contact per quarter.
 - Average face-to-face contacts in records from each CSB during the quarter ranged from a low of 1.9 to a high of 11.6.
 - The chart below provides this information for each of the 40 CSBs.

Case Management Face to Face Contacts During 90 Day Period by Location				
Community Services Board	Average Face to Face Visits	Percentage in the Office	Percentage in the Community	Percentage in the Clubhouse
Alexandria	10.5	59%	38%	3%
Alleghany Highlands	3.3	39%	61%	0%
Arlington	5.6	64%	32%	4%
Blue Ridge	1.9	68%	32%	0%
Central Virginia	3.6	78%	22%	0%
Chesapeake	4.8	33%	65%	2%
Chesterfield	4	20%	60%	20%
Colonial	5.5	71%	20%	9%
Crossroads	4	53%	40%	8%
Cumberland Mountain	2.7	63%	37%	0%
Danville-Pittsylvania	3.6	39%	56%	6%
Dickenson	2.8	71%	18%	11%
District 19	4	80%	13%	8%
Eastern Shore	3.7	8%	84%	8%
Fairfax-Falls Church	6.1	58%	40%	2%
Goochland-Powhatan	6	98%	0%	2%
Hampton-Newport News	2.7	30%	63%	7%
Hanover County	11.4	27%	72%	1%
Harrisonburg-Rockingham	3.4	53%	29%	18%
Henrico Area	4.2	60%	40%	0%
Highlands	4.8	58%	25%	17%
Loudoun	4.2	64%	17%	19%
Middle Peninsula-NN	4.8	31%	69%	0%
Mt. Rogers	3.8	39%	42%	18%
New River Valley	2.9	52%	21%	28%
Norfolk	6.9	28%	54%	19%
Northwestern	3	67%	20%	13%
Piedmont	4	58%	43%	0%
Planning District One	3.8	53%	47%	0%
Portsmouth	4.6	35%	65%	0%
Prince William	11.6	34%	66%	0%
Rappahannock Area	5.8	53%	45%	2%
Rappahannock-Rapidan	3.3	20%	67%	13%
Region Ten	3.7	86%	14%	0%
Richmond Behavioral Health Authority	9.3	42%	58%	0%
Rockbridge	6.6	56%	14%	30%
Southside	3.9	26%	62%	13%
Valley	5.4	31%	43%	26%
Virginia Beach	8.8	61%	34%	5%
Western Tidewater	2.8	61%	21%	18%

No recommendation

Quality of Care Finding E.2: The location where case managers visit with consumers is split fairly evenly between home/community settings and office based settings.

- The OIG review of case records for the 90-day period immediately prior to the site visits showed the following pattern regarding the location of visits between case managers and consumers:
 - Case manager's office or CSB office – 49%
 - Clubhouse or other day support program – 7%
 - Consumer's home or out in the community with the consumer shopping, at doctor's offices, etc. – 43%

The chart on the previous pages provides information on location of visit for each CSB.

- Few consumers stressed the importance of having their visits with case managers occur at home. They preferred to see their case managers at the office 46 percent of the time, followed by the clubhouse (29 %) and in the home or community (24%).
- All but one of the 83 supervisors interviewed stressed that case management should be primarily an outreach, “out of the office” activity. They indicated that this emphasis on home visits reflects the importance of assessing how the consumer is managing in his or her natural environment. Such direct observations in the home are considered necessary to assure an accurate understanding the consumer's situation.
- Case managers tended to agree, with 83 percent saying that it is important that the majority of face-to-face visits should be home visits.
- The recovery model would suggest that the consumer's opinion and preference about the location of the visit is of critical importance.
- Professional literature stresses the importance of outreach – seeing the consumer in his or her home.

Quality of Care Recommendation E.2: It is recommended that each CSB review current practice regarding the location where case managers visit with consumers to:

- Understand clearly what the current practice is.
- Identify barriers that may prevent visits in the location(s) preferred by consumers and most advantageous to the provision of effective services.

It is further recommendation that CSBs:

- Assess whether or not current practice is consistent with consumer preference.
- Develop strategies for eliminating any identified barriers.
- Establish any guidance that may facilitate greater flexibility in where case management visits take place.

DMHMRSAS Comment: DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation.

Quality of Care Finding E.3: Average caseload sizes for case management are higher than national standards and higher than case managers, supervisors and consumers think is appropriate to ensure highest quality services.

- Caseload sizes in Virginia average 39.1 per FTE - higher than the nationally recommended standard of 25 for heterogeneous caseloads of persons with serious and persistent mental illnesses. (National Association for Case Management and other sources). Thirty-seven of the 40 CSBs (92.5%) have average caseloads for mental health case managers that exceed this recommended average of 25.
- The following chart provides information regarding mental health case management caseload size for the 40 CSBs:

AVERAGE CASE MANAGER CASELOAD	
	Caseloads As Reported by CSBs
Alexandria	20.0
Alleghany Highlands	30.6
Arlington	41.9
Blue Ridge	64.6
Central Virginia	50.0
Chesapeake	37.1
Chesterfield	61.1
Colonial	42.9
Crossroads	47.4
Cumberland Mountain	56.9
Danville-Pittsylvania	38.3
Dickenson	71.5
District 19	35.5
Eastern Shore	35.3
Fairfax-Falls Church	44.8
Goochland-Powhatan	24.7
Hampton-Newport News	41.9
Hanover County	31.3
Harrisonburg-Rockingham	38.9
Henrico Area	41.0
Highlands	33.0
Loudoun	35.0
Middle Peninsula-NN	28.6
Mt. Rogers	32.9
New River Valley	31.1
Norfolk	32.4
Northwestern	37.4
Piedmont	50.2
Planning District One	38.1
Portsmouth	20.4
Prince William	36.9
Rappahannock Area	38.8
Rappahannock-Rapidan	30.3
Region Ten	41.3
Richmond Behavioral H. A.	41.1
Rockbridge	29.7
Southside	32.4
Valley	36.4
Virginia Beach	27.1
Western Tidewater	54.3
Statewide Average	39.1

* The CSB survey of case management caseloads included all staff that provide case management whether on a Dedicated Case Management Team or a Multifunctional Team where staff may spend a relatively small percentage of time in case management duties. The OIG converted these figures to full time equivalents (FTE).

Average caseloads for each CSB sorted by caseload size can be found in Attachment D.

- Case managers feel strongly (61%) that their caseloads are too large for them to do all they think they should for the persons they serve.
- The leading suggestion from case managers, supervisors, and even many consumers, is that caseload sizes should be reduced by adding additional case managers. Consumers often commented on the large caseloads carried by their case managers and noted that they might receive more visits from case managers and easier access if the caseloads were smaller.
- CSBs were asked how many more case managers would be needed to provide adequate levels of service to all the persons in need of case management. Responses are provided below:

Number Of Additional Case Managers Needed Per CSBs			
Alexandria	*	Highlands	*
Alleghany Highlands	3	Loudoun	4**
Arlington	6	Middle Peninsula-NN	4
Blue Ridge	10	Mt. Rogers	3
Central Virginia	10	New River Valley	0
Chesapeake	1	Norfolk	*
Chesterfield	4.5	Northwestern	10
Colonial	2	Piedmont	6
Crossroads	*	Planning District One	*
Cumberland Mountain	5	Portsmouth	2
Danville-Pittsylvania	4	Prince William	6
Dickenson	3	Rappahannock Area	7
District 19	2	Rappahannock-Rapidan	8
Eastern Shore	0	Region Ten	6
Fairfax-Falls Church	82	Richmond Behavioral H. A.	5
Goochland-Powhatan	1	Rockbridge	1
Hampton-Newport News	10	Southside	8
Hanover County	1	Valley	10
Harrisonburg-Rockingham	4	Virginia Beach	2
Henrico Area	6	Western Tidewater	2
STATEWIDE TOTAL - 234.5 Positions			

* These CSBs did not provide a specific number of needed positions.

** This CSB reported needing therapists with CM duties.

- At the current time there are no state established caseload standards for CSB case managers who provide services to individuals with mental health problems or individuals with serious mental illness.

Quality of Care Recommendation E.3.a: It is recommended that DMHMRSAS study the advisability of establishing a caseload standard for CSB case managers who work with individuals with serious mental illness and establish such a standard if it is determined advisable.

DMHMRSAS Response: *As a part of its mission to identify a recovery-oriented case management model, the Case Management Workgroup will study the advisability of establishing a state standard for caseload size and, if such a standard is deemed advisable, will recommend its establishment to the responsible DMHMRSAS and DMAS offices.*

Target date: Convene Workgroup by November 15, 2006. Preliminary recommendations regarding model, credentialing, caseload standards, curriculum and necessary resources by August 1, 2007.

Quality of Care Recommendation E.3.b: It is recommended that DMHMRSAS seek additional resources to increase the number of CSB case managers who work with individuals with serious mental illness in order to lower the average caseload. If it is determined that a state standard for such caseloads is advisable, it is recommended that this standard serve as the guideline for determining how many additional case managers are needed.

DMHMRSAS Response: *DMHMRSAS will consider the development of a Case Management funding initiative, consistent with the work of the Case Management Workgroup, to reduce caseloads as part of its FY 2009-10 budget request.*

Target date: Budget request developed by October 30, 2007.

Quality of Care Finding E.4: Case management service recipients have the same access to and receive the same level of case management service regardless of eligibility for Medicaid as a payment source. However, Medicaid recipients do have greater access to other services such as mental health support services, transportation, affordable medications and outpatient services.

- Forty-eight percent of the persons who receive mental health case management from CSBs do not receive Medicaid.
- All CSB case management supervisors and most all of the case managers who were interviewed by OIG inspectors reported no differences between Medicaid-funded Targeted Case Management (TCM) and case management services received by persons not funded by Medicaid. Only 12 percent of case managers said persons without Medicaid might be less likely to receive the minimum of a monthly contact that a TCM client must receive.
- Based on extensive record reviews and interviews with case managers and consumers, OIG inspectors did not detect variation in the level of case management services received by persons with Medicaid funding and those without dedicated funding for this service.

- The overwhelming majority of comments by case managers regarding the difference in access to services based on Medicaid status focused on other services that non-Medicaid consumers have less access to or have to pay for out of pocket. This includes services such as mental health support services, transportation to service appointments, affordable medications, and outpatient therapy.

Quality of Care recommendation B.4.a is also in support of this finding.

F. Case Manager Preparation and Support

Case managers must have sound clinical knowledge and the skills and training specific to the wide range of tasks a case manager must provide. Case management is an essential service and its providers must be supported and recognized as core mental health professionals.

Quality of Care Finding F.1: Case managers and supervisors have appropriate education levels for their positions.

- CSB executive directors certify case managers' possession of needed knowledge, skills, and abilities according to Medicaid provider requirements. There is no externally mandated degree requirement.
- Case manager's educational and licensure levels vary across the state. Ninety-three percent of case managers have a bachelor's degree, master's degree, are licensed as an LCSW/LPC, or are nurses. The percentage of various educational and licensure levels across the CSB system is provided below. CSB specific information can be found in Attachment E.

Educational Levels of Case Managers	Nurses	LCSW/LPC	Master's	Bachelor's	<B.A.
Percentage	8%	21%	22%	42%	7%

- CSBs that employ the largest numbers of case managers with master's degrees plus licensure (Arlington, Central Virginia, District 19, Fairfax-Falls Church, Loudoun, and Prince William) tend to use case managers to also provide outpatient therapy or serve as a specialist on another dedicated functional team, such as residential services.
- The OIG inspectors found the case management supervisors who provide program leadership to be very experienced. Their dedication to the staff and consumers was evident throughout the interviews that were completed.
- The average tenure for division directors who oversee casement services is eight years in their current position. This average for case management supervisors is 8.3 years.

No recommendations

Quality of Care Finding F.2: Case managers receive little training in topics specifically related to case management.

- In discussions with case managers and in reviewing agency-provided training schedules, OIG staff noted very little training specific to the unique role of the case manager.
- Few, if any, new case managers enter employment at CSBs with formal training or professional preparation to be a case manager.
- Case managers report they are unprepared for work with persons with co-occurring MI/MR issues.
- Case managers do not have a statewide organization or other convenient way to connect with each other, share training and practice experiences, and otherwise enhance the sense of professionalism in the case management role.

Quality of Care Recommendation F.2.a: It is recommended that DMHMRSAS and DMAS, with the involvement of CSBs, study the value of developing certification standards for case managers.

DMHMRSAS Response: DMHMRSAS will initiate a meeting with DMAS to update information available on the case management certification process that is in place at this time and the regulatory requirements for this activity. This information will be provided to the Case Management Workgroup, which will study whether to develop new or additional certification standards for case managers. The Case Management Workgroup will identify to DMHMRSAS the resources necessary to develop a training curriculum and certification process, conduct trainings, and to support and sustain such an initiative. DMHMRSAS will propose the development of new resources within the department to meet these needs.

Target date: Convene Workgroup by November 15, 2006. Preliminary recommendations regarding model, credentialing, caseload standards, curriculum and necessary resources by August 1, 2007

Quality of Care Recommendation F.2.b: It is recommended that CSBs consider the development of regional and/or statewide forums that will facilitate learning for case managers and enhancement of their professional role.

Quality of Care Recommendation C.1 is also in support of this finding.

DMHMRSAS Comment: DMHMRSAS supports these findings and will work collaboratively with the CSBs to address this recommendation.

Quality of Care Finding F.3: Case managers, supervisors – even many consumers – are of the opinion that paperwork requirements interfere with service provision rather than support it.

- The biggest source of case manager dissatisfaction with the support they receive to do their jobs is the burden of required paperwork.
- Sixty percent of case managers listed paperwork burdens as the least favorite aspect of their jobs.
- Seventy-six percent of case managers rated paperwork requirements in the following way - “(paperwork) *interferes with service provision, rather than supports it*”.
- Supervisors listed paperwork burdens as the number one issue that is needed to improve case management services. This was tied with the need for more case managers in order to lower caseload sizes.

Quality of Care Recommendation F.3: It is recommended that as DMHMRSAS and DMAS review and amend their respective regulations and inspection procedures that they seek ways to streamline and minimize data and record keeping requirements in an effort to allow case managers to maximize the amount of time they are available to consumers.

DMHMRSAS Response: *Currently, the Consumer Service Record Workgroup - which includes membership from DMHMRSAS, DMAS, and CSBs - is working to provide “streamlining guidance” to CSBs on service documentation that meets DMHMRSAS and DMAS regulations in the most efficient, least burdensome manner. DMHMRSAS Licensing Regulations pertaining to Case Management will be included in the overall review of licensing regulations that will take place over the next twelve months.*

Target date: Ongoing

Quality of Care Finding F.4: Salaries for CSB case managers at some CSBs are very low. Low salaries are considered a major problem at some CSBs and contribute to high turnover and interference with the continuity of care

- The entry-level salary for CSB mental health case managers ranges from \$21,681 at Mt. Rogers CSB to \$43,575 at Prince William CSB. The average entry-level case manager salary statewide is \$30,545. See Attachment F for salary information by CSB.
- The average current salary for CSB mental health case managers ranges from \$25,000 at Mt. Rogers CSB to \$56,000 at Fairfax-Falls Church CSB. The average current salary statewide for case managers is \$35,158. See Attachment F for salary information by CSB.
- Case managers often noted in interviews with OIG inspectors that low salaries are a concern and one reason why many case managers find it difficult to stay in the role for many years. Quite often, case managers in discussion sessions, suggested

that they ought to be paid at least comparably to public school teachers. The following comparison between CSB case manager and public school teacher salaries indicates that case manager salaries lag behind teachers:

Average Annual salaries (adjusted for 234 days/year)	CSB Case Managers	Public School Teachers
Entry Level	\$30,545	\$37,351
Experienced	\$35,158	\$51,504

- For the school year 2004-2005, Virginia entry-level public school teachers were paid an average salary of \$31,924 for 200 working days. (Source – Virginia Department of Education) When this figure is adjusted to the average number of working days for case managers (234 – based on state employee averages), the comparable entry-level salary for teachers is \$37,351.
- For the same period, the average salary for all teachers was \$43,936 for 200 days, adjusted to a comparison figure of \$51,504 for year round work.
- Case managers pay is closer to teachers’ salaries at entry (81 percent of teachers’ entry level pay), than after experience (68 percent of average pay for teachers with experience).
- Supervisors rated raising case management salaries as the third most important needed improvement for case management.
- Only a handful of CSBs offer career path promotional opportunities for persons who desire to remain case managers.

Quality of Care Recommendation F.4: It is recommended that each CSB conduct a review to determine if current salary ranges for case managers are having any negative impact on continuity of care for consumers who receive case management services and develop strategies to address any problems that are identified.

DMHMRSAS Comment: *DMHMRSAS supports this finding and will work collaboratively with the CSBs to address this recommendation.*

Section V

Appendix

- A. Quality Statements and Indicators
- B. Number of Adults Receiving Mental Health Case Management
- C. Model for Delivery of MH Case Management Services
- D. Average Case Management Caseloads Reported by CSBs
- E. Case Manager Education/Licensure
- F. Salaries for CSB Mental Health Case Managers
- G. Survey Questionnaires and Checklists
 - (Actual documents are available with the website version of this report found at www.oig.virginia.gov)
 - 1. Survey of Adult Mental Health Case Management Services
 - 2. Case Manager Interview
 - 3. Consumer Interview
 - 4. CSB Case Manager Record Review
 - 5. Supervisor Interview
 - 6. Stakeholder Survey

Mental Health Case Management Quality Statements and Indicators

1. Case management services are consumer-centered and consumer-driven.
 - Consumers have choice in receiving case management services and in selecting or changing case managers.
 - Case management and service plans reflect the consumer's needs and goals and are developed by the consumer, working with the case manager.
 - Consumers value the case management services they receive.
 - The plan and services provided are responsive to the consumer's needs, strengths, and goals.
 - Consumers have convenient and timely access to their case managers.
 - Consumers have access to peer support providers.
2. Case management services coordinate needed services in a comprehensive and efficient manner.
 - The case manager identifies resources, arranges for needed services, and coordinates services according to the consumer's needs and plans.
 - The medical care needs of consumers are closely monitored and services are arranged and coordinated as required.
 - Case management services work closely with CSB clinical and support services to provide a coordinated package of mental health recovery services.
 - Community resources (housing, transportation, jobs and job training, financial assistance, etc.) are available as needed for community living at the highest possible levels of independence and integration.
 - Case managers monitor and evaluate the provision of services needed by the consumer and included in the plan.
 - Case managers advocate for the needs of their consumers and feed into the CSB's responsibility to plan and develop needed mental health and community services.
 - Case management services are appropriately supportive of consumers during periods of crisis and hospital care.
3. Case management services are guided by the recovery model and are a principle means for a consumer to plan and implement his/her own recovery.
 - The CSB's mission and value statements reflect the recovery model and the vision statement of the DMHMRSAS.
 - Case managers have received training in the recovery model.

- Case management records and procedures reflect and support recovery-based service models.
- Case managers embrace and demonstrate the values and principles of the recovery model.

4. Consumers and case managers share a constructive interpersonal helping connection that fosters trust, cooperation and support for each consumer's recovery.

- Consumers feel that their case managers listen to them, are interested in their welfare, believe in them, and share their hope for recovery.
- Case managers provide supportive counseling and demonstrate a good clinical connection with the persons they serve.
- The case management relationship is characterized by continuity of care, including reliable, long-term tenure of the consumer-case manager relationship with minimal interruption and change due to turnover and reorganization.
- Case managers and consumers share and agree on assessment of needs, services, and the value of services provided.

5. Case management is an active, positive service that reaches out to consumers and provides continuing, active supports.

- Case management is a vigorous, active service, with frequent face-to-face and collateral contacts provided at a level sufficient to assure positive outcomes, guided by consumer preferences.
- The majority of case management services are provided on an outreach basis, out in the community at locations preferred by consumers.
- Caseload sizes are sufficiently small to allow thorough, comprehensive case management services based on consumer's needs and preferences.
- The CSB is able to employ sufficient numbers of case managers to assure appropriate caseload sizes and effective services.
- High quality case management services are available to all persons who need such services, regardless of their ability to pay for them.

6. Case managers are qualified, well prepared, and supported in their roles.

- Case managers have the required knowledge, skills and abilities to provide case management services.
- Case managers receive active, ongoing training in topics that are specific to the varied demands of the case management role, including case management skills, dual diagnosis needs, service resources, assessment and coordination of medical needs, cultural competence, etc.
- Documentation requirements, provision of technological supports (computers, electronic records, etc.), and provision of other supports (agency vehicles, for example) support and enable efficient and effective case management services.
- CSBs are able to recruit and retain qualified case managers.

- Case managers enjoy their jobs and receive professional stimulation and gratification from their work with the persons they serve.
- Case managers feel their services are valued and respected by the treatment teams.

Attachment B

Number of Adults Receiving Mental Health Case Management								
Community Services Board	Total Number Adults with SMI in Service	Number Receiving MH Case Mgmt	Percentage Receiving Case Mgmt		Number Receiving Case Mgmt with Medicaid	Percent of Case Mgt Recipients With Medicaid	Number Receiving Case Mgmt without Medicaid	Percent of Case Mgt Recipients without Medicaid
Alexandria	492	307	62%		124	40%	183	60%
Alleghany Highlands	241	153	63%		130	85%	23	15%
Arlington	928	799	86%		251	31%	548	69%
Blue Ridge	1267	876	69%		479	55%	397	45%
Central Virginia	1804	1540	85%		975	63%	565	37%
Chesapeake	950	367	39%		143	39%	224	61%
Chesterfield	711	607	85%		290	48%	317	52%
Colonial	472	359	76%		111	31%	248	69%
Crossroads	702	583	83%		390	67%	193	33%
Cumberland Mountain	842	796	95%		477	60%	319	40%
Danville-Pittsylvania	528	366	69%		232	63%	134	37%
Dickenson	284	251	88%		167	67%	84	33%
District 19	1026	828	81%		564	68%	264	32%
Eastern Shore	249	159	64%		105	66%	54	34%
Fairfax-Falls Church	3128	3076	98%		885	29%	2191	71%
Goochland-Powhatan	115	115	100%		37	32%	78	68%
Hampton-Newport News	2108	667	32%		477	72%	190	28%
Hanover County	203	203	100%		60	30%	143	70%
Harrisonburg-Rockingham	560	389	69%		202	52%	187	48%
Henrico Area	863	863	100%		323	37%	540	63%
Highlands	572	572	100%		382	67%	190	33%
Loudoun	1075	1075	100%		102	9%	973	91%
Middle Peninsula-NN	787	286	36%		253	88%	33	12%
Mt. Rogers	1746	461	26%		361	78%	100	22%
New River Valley	730	316	43%		160	51%	156	49%
Norfolk	1012	921	91%		532	58%	389	42%
Northwestern	1443	439	30%		278	63%	161	37%
Piedmont	1298	552	43%		357	65%	195	35%
Planning District One	1024	922	90%		522	57%	400	43%
Portsmouth	600	129	22%		79	61%	50	39%

Prince William	603	421	70%		147	35%	274	65%
Rappahannock Area	1271	306	24%		178	58%	128	42%
Rappahannock-Rapidan	668	182	27%		140	77%	42	23%
Region Ten	1625	733	45%		518	71%	215	29%
Richmond Behavioral H. A.	1495	1295	87%		848	65%	447	35%
Rockbridge	241	129	54%		96	74%	33	26%
Southside	573	235	41%		223	95%	12	5%
Valley	565	380	67%		190	50%	190	50%
Virginia Beach	1942	671	35%		292	44%	379	56%
Western Tidewater	649	619	95%		289	47%	330	53%
STATE-WIDE TOTAL	37392	23948	64%		12369	52%	11579	48%

Attachment C

Model for Delivery of MH Case Management Services						
	Staff Dedicated to Case Management	Staff Duties Include Other Services	Levels or Tiers	Mixed Needs in Caseload	Caseload Limits or Cap	Wait List Protocol for CM
Alexandria	X	X		X	25	yes
Alleghany Highlands	X			X	35-40	no
Arlington		X	X		various	no
Blue Ridge	X			X	no	no
Central Virginia	X	X	X		no	yes
Chesapeake	X			X	no	no
Chesterfield	X			X	no	no
Colonial	X		X		no	no
Crossroads	X			X	no	no
Cumberland Mountain	X			X	no	no
Danville-Pittsylvania	X		X		no	no
Dickenson		X		X	no	no
District 19	X			X	48	yes
Eastern Shore	X			X	50	no
Fairfax-Falls Church	X	X	X		various	no
Goochland-Powhatan	X		X		no	no
Hampton-Newport News	X			X	35	no
Hanover County		X		X	no	no
Harrisonburg-Rockingham	X		X		no	no
Henrico Area	X		X		no	no
Highlands	X			X	35-40	no
Loudoun		X	X		various	no
Middle Peninsula-NN	X			X	40	no
Mt. Rogers	X	X		X	40	no
New River Valley	X			X	45	no
Norfolk	X		X		various	no
Northwestern	X			X	no	yes
Piedmont	X			X	no	yes
Planning District One	X			X	50	no
Portsmouth	X			X	no	no
Prince William	X	X	X		no	yes
Rappahannock Area	X		X		21, 42	yes
Rappahannock-Rapidan	X		X		30	yes
Region Ten	X			X	no	no
Richmond Behavioral H. A.	X		X		various	no
Rockbridge	X			X	35,40	no
Southside	X			X	45	no
Valley	X		X		no	no
Virginia Beach	X			X	no	yes
Western Tidewater	X		X		no	no

Appendix D

Average Case Mgt Caseloads Reported by CSBs		
1st Quartile	Alexandria	20.0
	Portsmouth	20.4
	Goochland-Powhatan	24.7
	Virginia Beach	27.1
	Middle Peninsula-NN	28.6
	Rockbridge	29.7
	Rappahannock-Rapidan	30.3
	Alleghany Highlands	30.6
	New River Valley	31.1
	Hanover County	31.3
2nd Quartile	Norfolk	32.4
	Southside	32.4
	Mt. Rogers	32.9
	Highlands	33.0
	Loudoun	35.0
	Eastern Shore	35.3
	District 19	35.5
	Valley	36.4
	Prince William	36.9
	Chesapeake	37.1
3rd Quartile	Northwestern	37.4
	Planning District One	38.1
	Danville-Pittsylvania	38.3
	Rappahannock Area	38.8
	Harrisonburg-Rockingham	38.9
	Henrico Area	41.0
	Richmond Behavioral H. A.	41.1
	Region Ten	41.3
	Arlington	41.9
	Hampton-Newport News	41.9
4th Quartile	Colonial	42.9
	Fairfax-Falls Church	44.8
	Crossroads	47.4
	Central Virginia	50.0
	Piedmont	50.2
	Western Tidewater	54.3
	Cumberland Mountain	56.9
	Chesterfield	61.1
	Blue Ridge	64.6
	Dickenson	71.5

Attachment E

Case Manager Education/Licensure											
	Nurses		Licensed		Master's		Bachelor's		< Bachelor's		Total
	#	%	#	%	#	%	#	%	#	%	
Alexandria	0	0%	4	18%	7	32%	8	36%	3	14%	22
Alleghany Highlands	0	0%	0	0%	0	0%	3	60%	2	40%	5
Arlington	4	8%	16	32%	16	32%	14	28%	0	0%	50
Blue Ridge	5	19%	2	7%	3	11%	12	44%	5	19%	27
Central Virginia	3	3%	12	11%	25	23%	55	50%	14	13%	109
Chesapeake	2	13%	2	13%	6	40%	5	33%	0	0%	15
Chesterfield	0	0%	2	15%	6	46%	4	31%	1	8%	13
Colonial	0	0%	0	0%	4	31%	9	69%	0	0%	13
Crossroads	3	10%	0	0%	5	17%	16	55%	5	17%	29
Cumberland Mountain	1	6%	1	6%	5	31%	8	50%	1	6%	16
Danville-Pittsylvania	3	14%	0	0%	5	24%	13	62%	0	0%	21
Dickenson	0	0%	0	0%	2	22%	7	78%	0	0%	9
District 19	2	4%	20	38%	14	27%	16	31%	0	0%	52
Eastern Shore	1	13%	0	0%	0	0%	6	75%	1	13%	8
Fairfax-Falls Church	28.5	15%	107.5	57%	27.5	15%	21.5	11%	2	1%	187
Goochland-Powhatan	0	0%	0	0%	2	67%	1	33%	0	0%	3
Hampton-Newport News	2	7%	1	3%	7	24%	18	62%	1	3%	29
Hanover County	0.54	4%	6	48%	5	40%	1	8%	0	0%	12.54
Harrisonburg-Rockingham	1	9%	0	0%	3	27%	7	64%	0	0%	11
Henrico Area	2	11%	2	11%	6	33%	8	44%	0	0%	18
Highlands	0	0%	0	0%	7	33%	14	67%	0	0%	21
Loudoun	9	6%	33	23%	46	32%	44	31%	12	8%	144
Middle Peninsula-NN	0	0%	0	0%	0	0%	6	60%	4	40%	10
Mt. Rogers	1	4%	9	38%	4	17%	8	33%	2	8%	24
New River Valley	4	24%	1	6%	3	18%	9	53%	0	0%	17
Norfolk	2	4%	1	2%	13	29%	28	62%	1	2%	45
Northwestern	1	4%	1	4%	2	7%	11	39%	13	46%	28
Piedmont	2	11%	2	11%	3	17%	11	61%	0	0%	18
Planning District One	11	33%	0	0%	0	0%	12	36%	10	30%	33
Portsmouth	0	0%	0	0%	0	0%	9	90%	1	10%	10
Prince William	0	0%	13	45%	7	24%	8	28%	1	3%	29
Rappahannock Area	0	0%	0	0%	0	0%	7	100%	0	0%	7
Rappahannock-Rapidan	0	0%	0	0%	2	33%	4	67%	0	0%	6
Region Ten	1	3%	3	10%	6	21%	17	59%	2	7%	29
Richmond Behavioral H. A.	1	3%	0	0%	5	16%	25	81%	0	0%	31
Rockbridge	0	0%	0	0%	1	20%	4	80%	0	0%	5
Southside	0	0%	0	0%	0	0%	7	88%	1	13%	8
Valley	4	19%	3	14%	0	0%	12	57%	2	10%	21
Virginia Beach	0	0%	3	11%	10	38%	13.5	51%	0	0%	26.5
Western Tidewater	3	14%	1	5%	4	19%	13	62%	0	0%	21
Total	97.04	8%	245.5	21%	261.5	22%	495	42%	84	7%	1183.04

Attachment F

Salaries for Case Managers at the CSBs							
	Starting Salary	Current Salary			Ranking of Starting Salary		Ranking of Current Salary
Alexandria	36,000	49,000		Prince William	43,575	Fairfax-Falls Church	56,000
Allegheny Highlands	27,141	28,509		Fairfax-Falls Church	42,000	Arlington	51,700
Arlington	38,890	51,700		Arlington	38,890	Prince William County	51,261
Blue Ridge	28,094	31,162		Virginia Beach	37,355	Alexandria	49,000
Central Virginia	24,048	29,694		Rappahannock Area	36,608	Virginia Beach	46,117
Chesapeake	34,803	37,592		Henrico	36,129	Hanover	45,000
Chesterfield	36,006	37,895		Chesterfield	36,006	District 19	42,108
Colonial	29,154	32,207		Alexandria	36,000	Henrico	41,585
Crossroads	29,000	32,226		Region Ten	35,144	Loudoun County	41,432
Cumberland Mountain	22,848	27,296		Chesapeake	34,803	Rappahannock Area	38,532
Danville-Pittsylvania	29,824	33,500		Loudoun County	34,671	Chesterfield	37,895
Dickenson County	26,244	27,837		RBHA	33,969	Chesapeake	37,592
District 19	27,342	42,108		Hanover	33,895	Region Ten	37,000
Eastern Shore	27,115	29,032		Goochland-Powhatan	32,201	Norfolk	36,813
Fairfax-Falls Church	42,000	56,000		Rappahannock-Rapidan	31,585	Goochland-Powhatan	34,952
Goochland-Powhatan	32,201	34,952		Hampton-Newport N	31,296	Portsmouth	34,950
Hampton-Newport News	31,296	32,520		Norfolk	29,987	RBHA	34,684
Hanover	33,895	45,000		Portsmouth	29,916	Rappahannock-Rapidan	33,696
Harrisonburg-Rockingham	29,308	31,435		Danville-Pittsylvania	29,824	Danville-Pittsylvania	33,500
Henrico	36,129	41,585		Harrisonburg-Rockingham	29,308	Hampton-Newport News	32,520
Highlands	24,798	27,077		Western Tidewater	29,253	Western Tidewater	32,289
Loudoun County	34,671	41,432		Colonial	29,154	Crossroads	32,226
Middle Peninsula-N. Neck	27,171	27,934		Crossroads	29,000	Colonial	32,207
Mt. Rogers	21,681	25,000		Southside	28,952	Southside	31,800
New River Valley	28,874	31,333		New River Valley	28,874	Harrisonburg-Rockingham	31,435
Norfolk	29,987	36,813		Blue Ridge	28,094	New River Valley	31,333
Northwestern	26,162	30,000		District 19	27,342	Blue Ridge	31,162
PD1	25,122	29,995		Middle Peninsula NN	27,171	Northwestern	30,000
Piedmont	23,670	27,609		Allegheny Highlands	27,141	PD1	29,995
Portsmouth	29,916	34,950		Eastern Shore	27,115	Central Virginia	29,694
Prince William County	43,575	51,261		Dickenson County	26,244	Rockbridge	29,447
Rappahannock-Rapidan	31,585	33,696		Northwestern	26,162	Eastern Shore	29,032
Rappahannock Area	36,608	38,532		Rockbridge	26,138	Allegheny Highlands	28,509
RBHA	33,969	34,684		Valley	25,844	Valley	28,100
Region Ten	35,144	37,000		PD1	25,122	Middle Peninsula-N. Neck	27,934
Rockbridge	26,138	29,447		Highlands	24,798	Dickenson County	27,837
Southside	28,952	31,800		Central Virginia	24,048	Piedmont	27,609
Valley	25,844	28,100		Piedmont	23,670	Cumberland Mountain	27,296
Virginia Beach	37,355	46,117		Cumberland Mountain	22,848	Highlands	27,077
Western Tidewater	29,253	32,289		Mt. Rogers	21,681	Mt. Rogers	25,000

**Office of the Inspector General
CSB Adult Mental Health Case Management Review**

Case Manager Interview

Case Management CSB: _____

Date: _____

1. How long have you been a case manager with this team, serving essentially the same persons? _____
2. If you only work part time or only part of your total time is devoted to case management, how many hours per week are you assigned to case management duties? _____
3. How many persons do you serve right now (caseload size)? _____
4. How often are you *expected* by your CSB to see each person face-to-face?
____every 90 days____monthly____every other week____weekly____no
stated expectations
5. How often are you *expected* by your CSB to make other direct contact (telephone) with the person?_
____every 90 days____monthly____every other week____weekly____no
stated expectations

Does this vary by level of case management or funding source? Please explain:

6. Here is a list of activities a case manager might provide for a person being served. . Indicate how important you think each of these duties is for you to provide in your role as case manager

Services or Activities	Currently Occurs	Does not Currently Occur	Very Important	Important	Not Important
Case manager coordinates treatment planning with all service providers.					
Case manager provides information and gets input from family (with consumer's permission), other service providers, etc.					
Case manager helps people experience community activities.					
Case manager monitors providers to assure service delivery occurs according to the ISP.					
Case manager evaluates services provided for consumers.					
Case manager advocates for consumers to be sure their needs are					

met.					
Case manager provides supportive counseling to consumers.					
Case manager provide crisis supports to the persons they serve.					
Case manager makes arrangements and assures that consumers receive medical services.					
Case managers assure that consumers have transportation to appointments, etc.					
Case managers assure that consumers receive educational services about mental illness, medications, coping skills, etc					
Case managers are available for contact outside					

normal business hours if needed. (not Emergency Services)					
Case managers help or arrange help for consumers to manage their money.					
The majority of the case manager's face-to-face contacts are in the consumer's home.					
Case managers visit people if they become hospitalized and help plan their discharge and return to the community and follow up.					
Case managers help people find and move into new apartments or homes.					

Services or Activities	Currently Occurs	Does Not Currently Occur	Very Important	Important	Not Important
Case managers are responsive to telephone contacts and consumers' needs to see them without undue delay.					
Consumers who are new to case management get to interview and select their own case managers.					
Consumers have opportunities to evaluate the quality of the case management services.					
Consumers are able to change to a different case manager if they wish.					

7. Indicate your agreement with the following statements:

Statements	Agree	Disagree
My caseload size is too large for me to do quality work with the people I serve.		
My agency attempts to limit how much I might do for clients on the basis of utilization management or revenue generation.		
My agency provides the training I need to be a good case manager.		
The expectations placed on me as a case manager are clear and consistent.		
I find being a case manager professionally stimulating and satisfying.		
I am able to continue my supportive relationship with the persons I serve for a period long enough not to cause disruption or strain to the consumers' need for continuity.		
I feel safe working out in the community or in the homes of the people I serve.		
The coordinating and linking aspects of case management that I provide are valued by the people I serve.		
The paperwork I must maintain is a major burden and it interferes with service provision, rather than supports it.		
My role as a case manager is respected by other members of the treatment team, e.g., doctors, nurses, therapists.		
Our agency allows consumers enough choice and self-determination in using its services.		
My agency has provided case managers with training and support regarding the recovery model for mental health services within the last two years.		
I am well prepared by training or experience to deal with co-occurring substance abuse disorders among the persons I serve.		
I am well prepared by training or experience to deal with co-occurring mental retardation needs among the persons I serve.		
I am well prepared by training and agency supports to relate to the cultural diversity of my clients (e.g., race, language, etc.)		

8. Are the consumers you serve able to access the following services adequately?

Services or Issues	Agree	Disagree
Consumers have access to a psychiatrist when they want or need to, without undue waiting..		
Consumers receive appropriate outpatient therapy services if they want and need it.		
Consumers have access to safe, affordable housing of their choice.		
Consumers receive adequate service planning, linkage, and coordination.		
Consumers receive needed job training, job support, or jobs.		
Consumers receive adequate community living skills training and support (e.g., residential support staff or Mental Health Support Staff - MHSS).		
Consumer' rights and privacy are protected at my agency.		
Persons receive adequate opportunity for choice and self-determination in their treatment at my agency.		
The persons I serve are able to access their prescribed medications affordably or free, as needed.		
Persons are helped in crisis intervention services in their homes or own community – not just hospitals		
The persons I serve have access to social opportunities, friendships, and relationships.		
The persons I serve enjoy good continuity of care – not too much change and turnover in the agency		
Consumers have access to services provided by peer supporters (other consumers, trained to work with them), not paid staff, if they wish.		

9. Which of these choices best describes how consumers' plans and goals are developed. Pick only one.

Case manager develops individual services plan (ISP) for the consumer, explains it, and asks consumer to sign it.	
Case manager involves consumers in developing their ISP, inviting the consumer to help create goals.	
Consumers substantially lead the development of their own need assessment and ISP, in their own words, with case manager supports.	

10. What is different about the services you provide to persons who are eligible for Medicaid Targeted Case Management and those who are not?

11. What do you like most about your job?

12. What do you like least about your job?

13. Does the name "case management?" accurately describe the services you provide for consumers? What would be a better name?

14. What is the mission of case management services?

15. Please list the values or principles that have been adopted by your agency to guide service delivery.

15. What one or two changes do you think are most needed to improve case management services in Virginia?

Office of the Inspector General
CSB Adult Mental Health Case Management Review
Consumer Interview

(to be completed by persons who are currently receiving case management services at a Virginia CSB)

Case Management CSB _____

Age: _____

1. How long have you had the **same** case manager? circle one

less than 6 months 6 mo - 1year 1-2 years 2-5 years 6-10 years
10+ years

2. How many case managers have you had in the last 5 years: circle one

1 2 3 4 5 6 more than 6

3. How often do you see your case manager face-to-face? circle one

weekly every other week monthly every 2-3 months less
than every 3 months

4. Where do you **most often** see your case manager (circle only one):

his/her office at clubhouse, job or other day activity at my home or
apartment in the community (restaurant, etc).

5. Where do you **prefer** to see your case manager (pick only one):

his/her office at clubhouse, job or other day activity at my home or
apartment in the community (restaurant, etc).

6. Here is a list of activities a case manager might provide for a person being served. First, answer if you receive this service or activity from your case manager. Second, tell us how important these services are to you – whether you get them now or not.

Services or activities available to persons receiving case management services	I receive this, or this does happen	I do not receive this, or this does not happen	Very Important	Important	Not Important
My case manager makes sure all my services work together to give me the most help.					
My case manager works with my family – if I want him or her to.					
My case manager provides supportive counseling to me.					
My case manager provides crisis support service when I need it.					
My case manager makes arrangements and makes sure that I receive medical services.					
My case manager makes					

sure that I have transportation to appointments, etc.					
My case manager makes sure that I receive educational services about mental illness, medications, coping skills, etc					
My case manager (not Emergency Services) is available for contact in the evenings or weekends if needed.					
My case manager helps me manage my money, or finds someone who can help me, if I need it.					

Services or activities available to persons receiving case management services	I receive this, or this does happen	I do not receive this, or this does not happen	Very Important	Important	Not Important
If I am hospitalized, my case manager continues to work with me and helps plan my discharge, return to the community, and follow up care.					
My case manager is easy to reach by phone.					
When I first entered case management I was able to interview and select my own case manager					
I have opportunities to evaluate the quality of the case management services I receive.					
I am able to change to a different case manager if I wish.					

7. Indicate your agreement with the following statements:

Statements	Agree	Disagree
My case manager listens carefully to what I say.		
My case manager sees me as an equal partner in my treatment program.		
My case manager treats me as a whole person, not as a psychiatric label or “case.”		
My case manager does not understand my experience as a person with mental health problems.		
My case manager leads me to be more dependent, not more independent.		
My case manager ignores my physical health.		
My case manager sees me when I need to be seen.		
My case manager supports my self-care and wellness.		
My case manager stands up for me to get the resources and services I need.		
My case manager helps me build on my strengths.		
My case manager is at least one person who believes in me.		
My case manager treats me with respect regarding my cultural background (race, language, etc.)		
My case manager believes that I can grow, change, and recover		

13. Do you have access to the services listed below?

Services or Issues	Agree	Disagree
see a psychiatrist when I want or need to, without undue waiting..		
see a therapist if I want and need to.		
safe, affordable housing of my choice.		
service planning, linkage, and coordination of all my services.		
job training, job support, or jobs.		
rights and privacy are protected at my agency.		
choice and self-determination in my treatment at my CSB.		
affordable or free medications as prescribed.		
help when I have a crisis in my home or own community – not just hospitals		

Services or Issues	Agree	Disagree
social opportunities, friendships, and relationships.		
good continuity of care – not too much change and turnover in the CSB		
a chance to work with other persons who have experienced mental illness (other consumers), not paid staff, if I wish.		

14. Which one of these choices is closest to the experience you have had?
Pick one only by checking the box that most applies

My case manager developed my individual services plan (ISP) for me, explained it and asked me to sign it.	
My case manager involved me in developing my ISP, inviting me to help create my goals and plan.	
My case manager helped me to take the lead in developing my own need assessment and ISP, in my own words.	

15. If you were to name case management something else, what would it be?

16. What do you like most about case management services?

17. What do you like least about case management services?

18. What one or two changes do you think are most needed to improve case management services at your CSB or in Virginia?

Thank you for completing this survey.

**Office of the Inspector General
CSB Case Manager Record Review**

Case Management CSB _____ Consumer Initials:

Reviewer _____ Case Manager Initials:

Date _____ MDCD TCM? _____ yes _____
no _____ cannot tell

Date for start of the quarter: _____

1. **Value: The consumer has maximum control of the development of his own need assessment and plan, or ISP.** (NOTE to OIG reviewers – these are in order of increasing consumer involvement or control. Select the **one** option that most closely fits what the plan presents with regard to choice and self-determination:

There is no record of consumer involvement with the ISP, except the signature.

It seems that the case manager wrote the plan and (perhaps) explained it to the consumer and asked him or her to sign it.

There is evidence that the case manager elicited and received input from

the consumer about the plan. The plan was developed by the case manager, but with real consumer input.

The ISP is judged to be **substantially** consumer driven, a self-directed plan,

supported by the case manager. The case manager may have written the ISP, but it is clearly the expression of the consumer's wishes and preferences, the consumer's own words are part of the plan.

2. **How many face-to-face contacts did the case manager have with the consumer in the last three months, and where did they occur?**

Record number of documented face-to-face contacts, by location:

Tally	Number
-------	--------

_____ in the case managers office or the clinic office building (e.g. in the waiting room, etc.)

_____ at the clubhouse or other day support program

_____ out in the community, e.g., restaurant, store

_____ in the consumer's home.

_____ **Total face-to-face in the last three months** (sum of the above, for the quarter)

3. How many other contacts did the case manager have with the consumer *directly* (by phone, email) in the last quarter?

Tally Number

_____ total other direct contacts in the last three months

4. Evidence that the case manager engaged in the following activities in the last quarter (check all that apply):

arrangement of medical services	
linkage or coordination of other services	
contact with family or natural supports	
evaluation of services received by consumer	
advocacy for consumer	
supportive counseling	
crisis support services	
medication education or supports	

**Office of the Inspector General
CSB Adult Mental Health Case Management Review**

Supervisor Interview

Case Management CSB: _____

Reviewer: _____ Respondent: _____

Date: _____ Phone: _____

Respondent: (circle one)

Case Management Supervisor Division director Executive Director

1. How long have you been in a position that supervises adult mental health case management services at this CSB? _____ years

2. How often do you *expect* your case managers to see each person face-to-face?

_____ every 90 days _____ monthly _____ every other week _____ weekly _____ no specific expectation

3. How often do you *expect* your case managers to make other direct contact (telephone) with the person?

_____ every 90 days _____ monthly _____ every other week _____ weekly _____ no specific expectation

4. What is your expectation of where case managers see their clients?

_____ mostly in their offices or at the clinic, e.g., with the doctor

_____ sometimes in their offices, sometimes the consumers' homes or out in the community

_____ mostly in the consumers' homes or out in the community

Comments:

5. What are the differences, if any, in case management received by persons who have Medicaid and qualify for TCM and those who do not?
6. The literature says that continuity of care – having reliable, familiar support systems - is important for stability and recovery for consumers. Is turnover of case managers a problem at your CSB?
7. What do you do to assure or increase consumer choice and self-determination in case management services?
8. When someone served by a case manager has a psychiatric hospitalization, what roles do your case managers play before, during, and after the hospitalization?
9. What provision is made for consumers to reach their case manager or a backup (not just ES) on evenings, weekends, holidays, or vacations?
10. Does the name “case management” accurately describe the services your case managers provide? What would be a better name?

- 11.. What do you do to assess or measure competence in all the skills that a case manager must have?
- 12.. What do you do to assure that your case managers are culturally competent to provide services to the group of consumers you serve?
13. What is your familiarity with the recovery model of supports for persons with mental illness, and what has your board done to help case managers understand and embrace this approach?
14. What one or two changes do you think are most needed to improve case management services in Virginia?

Office of the Inspector General
CSB Adult Mental Health Case Management Review

Stakeholder Survey

Note: This survey, in electronic form, is a Word document that has tables for the data fields. You can enter your answers directly onto the form. The box or line will expand to accommodate all your content. Save the completed survey as a Word document, then you can attach it to an email to send it in to the OIG. Send your completed surveys by March 31 to heather.glissman@oig.virginia.gov. If you wish, you may print the survey, fill it out with a pen or pencil, and fax it to the OIG at 804-786-3400. If you have any questions about the form, call John Pezzoli, at 804-840-3092 or email him at john.pezzoli@oig.virginia.gov.

1. Name of case management CSB you work with (state or private hospital staff, add rows to list the CSBs that you work with):

--

2. Relationship to CSB adult mental health case management	Family member of a person receiving case management services	Mental health services consumer	Staff of a state or private mental health hospital	Other, Please Describe
Indicate relationship by checking a box				

3. What are the strengths of the CSB case management program with which you are most familiar? State and private hospital staff, add rows and respond for each CSB you work with.

--

4. What are the needs for improvement of the CSB case management program with which you are familiar? State and private hospital staff, add rows and respond for each CSB.

--